

Documentation and note taking

Check What My Note Can Support

Clinicians | 10 to 15 minutes

A useful note should reflect the encounter that occurred. Use a deidentified example to check the basis for each important statement. This page does not create a record for you. It helps you notice omissions, copied assumptions, and wording that says more than the available information supports.

Review one planned statement. Label its source, connect it to care, and remove unsupported or unnecessary detail.

Identify the information source

Distinguish what you observed, what the person reported, and what you inferred. A direct quote should be accurate and relevant. Do not convert an unasked question into a negative finding or a draft suggestion into a completed intervention.

Check relevance and accuracy

Connect the concern, work completed, response, and actual plan where appropriate. Review copied text and generated drafts line by line. Verify required documentation elements in your setting separately; never invent time, services, consent, or assessment.

1. Which statement needs a clearer source or more precise wording?**2. What was observed, reported, inferred, or not assessed?****3. How is this detail relevant to the care provided?****4. What will I correct or verify before the note enters the record?****Clinical use and adaptation**

Use deidentified examples outside approved records. Follow current organizational, professional, payer, and jurisdictional requirements. Do not store client information in an unapproved tool or treat generated wording as evidence. This page cannot establish billing eligibility, medical necessity, or legal compliance.